Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS COUNTY HOSPITAL
P O BOX 660599
DALLAS TX 75266 0599

Respondent Name

NETHERLANDS INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1692-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "services based on emergency no authorization was needed'"

Amount in Dispute: $31,884.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Requestor asserts that the care provided was 'emergency' care not requiring preauthorization, but it does not meet the criteria set out in DWC Rule 133.2(3). There is insufficient documentation to show that the claimant's condition was acute and of sufficient severity so as to threaten serious jeopardy to bodily functions or the dysfunction of a body organ." "Notes generated on 10/13/10 indicate that the claimant was concerned about his left ankle because of a post infection to the hardware installed therein. He apparently stated that he had had an appointment the next day with his orthopedic specialist, but it had been canceled for unknown reasons so he went to the ER. He stated that he had no fever chills and that he had been on antibiotics for three months. Surgery was apparently performed because of a 'possible' infection. None of this indicates an 'emergency' as defined by the DWC."

Response Submitted by: Flahive, Ogden & Latson, Attorney At Law PC, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2010 Through October 19, 2010	Inpatient Hospital Surgical Services	$31,884.52	$18,398.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §133.2 sets out the criteria for medical emergency health care.
4. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
5. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
6. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 23, 2010
   - 851-000 –PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION UMD RECOMMENDS $0.00.

Issues

1. Did the requestor meet the requirements for a medical emergency in accordance with 28 Texas Administrative Code §133.2?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.2(3)(A) states, "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain , that the absence of immediate medical attention could reasonably be expected to result in…placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part." The Division finds that the requestor has supported the existence of a medical emergency. Having demonstrated a case of emergency, the requestor has met the requirements of 28 Texas Administrative Code §134.600(c). The Division concludes that the respondent's denial reason is not supported. Therefore, the disputed services will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.600(c)(1)(A) states in pertinent part, "The carrier is liable for all reasonable and necessary medical costs relating to the health care…listed in subsection (p) or (q) of this section only when the following situations occur…an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions)." The requestor has met the requirements for a medical emergency in accordance with 28 Texas Administrative Code §133.2. Therefore, reimbursement is recommended.

3. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:

   The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 909 is $12,866.39.

   This amount multiplied by 143% is $18,398.94.

   The total maximum allowable reimbursement (MAR) is $18,398.94.

   This amount less the amount previously paid by the respondent of $0.00 leaves an amount due to the requestor of $18,398.94.

   The Division concludes that the requestor is entitled to $18,398.94 reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $18,398.94.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $18,398.94 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 19, 2011
Signature	Medical Fee Dispute Resolution Officer	Date
		October 19, 2011
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.